

**INDIVIDUAL SERVICE PLAN (ISP)**

(Model Form)

**To be completed within 30 days of admission, updated every 6 months thereafter or more often when indicated by a change in the resident's condition**

Name - Resident	Admission Date
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Facility Name and Address

Date - Original ISP	Date - Six Month Progress Review	Date - Annual Evaluation	Date - Six Month Progress Review
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**SIGNATURE OF PARTICIPANTS**

Resident or Guardian	Resident or Guardian	Resident or Guardian	Resident or Guardian
Agent or Designated Representative	Agent or Designated Representative	Agent or Designated Representative	Agent or Designated Representative
Licensee or Administrator	Licensee or Administrator	Licensee or Administrator	Licensee or Administrator
Others	Others	Others	Others

**MEDICATIONS: (check one)**

- ☐ Controls own medication (HFS 83.33(3)(b))  
☐ Self administers own medication and staff supervises (HFS 83.33(3)(e))  
☐ Medications administered by CBRF staff (HFS 83.33(3)(e)) (medical order from a practitioner is required)  
☐ No medications

**NURSING PROCEDURES:**

- ☐ None    ☐ Yes (HFS 83.32(2)(a)3) If Yes, no. of hours per week \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CAPACITY FOR SELF DIRECTION: (HFS 83.32(2)(a)7) (check one)**

- ☐ Makes own decisions    ☐ Makes needs known  
☐ Needs assistance    ☐ Cannot make needs known

**RESIDENT HAS ADVANCE DIRECTIVES (HFS 83.33(2)(l))**

- ☐ No    ☐ Yes If yes, ☐ Activated    ☐ Not activated

**SUPERVISION: (HFS 83.33(2)(a) (check one)**

- ☐ Capable of self supervision  
☐ Needs some supervision; Describe: \_\_\_\_\_

\_\_\_\_\_

- ☐ 24-hour supervision

- ☐ Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CAPACITY FOR SELF CARE: (HFS 83.32(2)(a)6) (check one)**

- ☐ Independent  
☐ Needs some assistance  
☐ Needs total assistance  
☐ List any adaptive equipment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS

[illegible]

**PERSONAL CARE**

	Current Status	Frequency of Service and Service Provided	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes	Annual Evaluation List any changes	6 Month Progress Review List any changes
<b>Eating</b>							
<b>Special Diet</b>							
<b>Oral Care</b>							
<b>Dressing</b>							
<b>Grooming</b>							
<b>Bathing</b>							
<b>Toileting</b>							
<b>Other</b>							

**BEHAVIOR PATTERNS**

	Current Status	Frequency of Service and Service Provided	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes	Annual Evaluation List any changes	6 Month Progress Review List any changes
<b>Wandering</b>							
<b>Self-Abusive Behavior</b>							
<b>Propensity to Choke on Certain Foods</b>							
<b>Suicidal Tendencies</b>							
<b>Destructive of Property or Self, Physically or Mentally Abusive</b>							
<b>Evacuation Capability In Emergency</b>							
<b>Other</b>							

**PHYSICAL HEALTH** HFS 83.32(2)(a)1

	Current Status	Frequency of Service and Service Provided	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes Date: Signature:	Annual Evaluation List any changes Date: Signature:	6 Month Progress Review List any changes Date: Signature:
<b>General Health</b>							
<b>Chronic Illnesses</b>							
<b>Short-term Illnesses</b>							
<b>Recurring Illnesses</b>							
<b>Physical Disabilities</b>							
<b>Hearing</b>							
<b>Eye Sight</b>							
<b>Nursing Procedures</b>							

**MENTAL AND EMOTIONAL HEALTH**

	Current Status	Frequency of Service and Service Provided	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes Date: Signature	Annual Evaluation List any changes Date: Signature:	6 Month Progress Review List any changes Date: Signature
<b>Self Concepts</b>							
<b>Maturation</b>							
<b>Attitude</b>							
<b>Interaction with Others</b>							
<b>Aggressive/ Combative</b>							
<b>Verbal</b>							

**SOCIAL PARTICIPATION**

	Current Status	Frequency of Service and Service Provided	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes	Annual Evaluation List any changes	6 Month Progress Review List any changes
					Date: Signature:	Date: Signature:	Date: Signature:
<b>Interpersonal Relationships</b>							
<b>Leisure Time Activities</b>							
<b>Family Contacts</b>							
<b>Community Contacts</b>							
<b>Religious Activities</b>							
<b>Other</b>							

**INDEPENDENT LIVING SKILLS** Describe what skills are being taught to increase or maintain independence

	Current Status	Frequency of Service	Goal/Outcome	Service Provider Responsible	6 Month Progress Review List any changes Date: Signature:	Annual evaluation List any changes Date: Signature:	6 Month Progress Review List any changes Date: Signature
<b>Educational Skills</b>							
<b>Vocational Skills</b>							
<b>Money Management</b>							
<b>Communication Skills</b>							
<b>Food Preparation</b>							
<b>Shopping</b>							
<b>Use of Public Transportation</b>							
<b>Seeking/Retaining Employment</b>							
<b>Housekeeping Skills</b>							
<b>Other</b>							